DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/25/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G031	A. BUILDING _____ B. WING _____	10/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MULTI SERVICES, INC	4314 9TH STREET NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS On August 20, 2009, the State Agency (SA) received written notification of an incident from this agency. According to the notification, the alleged incident occurred on August 18, 2009 at approximately 11:20 P.M. The incident report described that a direct care staff observed Client #2 in the bed with Client #1. Client #2 had her finger inserted in Client #1's rectum. Due to the nature of the incident and the information obtained from the administrative review, an onsite investigation [#09-6465] was initiated on October 5, 2009 to verify compliance with federal regulatory requirements. Findings of the investigation ware based on observations in the group home, interviews with the group home management, direct care staff, and the review of Administrative and Habilitation records to include the agency's incident management system. As a result of this investigation, the State agency could not substantiate that the behavior of Client #2 had been exhibited prior to this incident. However a determination was made that the facility failed to be in compliance with the standard level requirements in Client Protections as evidenced by throughout this report.	W 000	Received 12/4/09 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not mat as evidenced by: Based on interview and record reviews, the governing body failed to exercise general policy and operating direction over the facility for one of	W 104		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Constance C. Reese — TITLE: Program Director — (X6) DATE: 12/4/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	09G031	BUILDING _____ A WING _____	10/09/2009

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COMMUNITY MULTI SERVICES, INC	4314 9TH STREET NW WASHINGTON, DC 20011

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W 104	Continued From page 1 the six clients residing in the facility. (Client #1) The findings include: 1. The facility's governing body failed to ensure that the Incident Management Coordinator completed a thorough internal investigation in accordance with the agency's policy and procedures. (See W154) 2. The facility's governing body failed to ensure its staff reported this incident timely in accordance with the agency's incident policy and procedures. (See W149) 3. The facility's governing body failed to ensure its direct care staff participated in ongoing incident management reporting in-service training in accordance with the agency's policy and procedures. (See W189)	W 104	1. In the future the Incident Management Coordinator will complete a thorough internal investigation.	12/2/09
			2. Cross reference 1379	10/23/09
			3. Cross reference 1222	10/23/09
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that the agency's incident reporting policies were implemented for one of the six clients that resided in the facility. (Client #1) The finding includes: The facility failed to ensure the implementation of its "Incident Management" policy as outlined	W 149	1. Client #2 will no longer share a room with any other individual.	8/19/09
			2. Client #1's one-to-one protocol will be updated and signed by all staff who work with Client #1.	11/1/09
			3. Staff will receive training on Neglect and Abuse.	11/1/09

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W 149	Continued From page 2 below: On August 20, 2009, the State Agency received written notification of an incident from this agency. According to the notification the alleged incident occurred on August 18, 2009 at approximately 11:20 P.M. The incident report described that on August 19, 2009 at approximately 5:00 P.M. a direct care staff reported to the facility's Qualified Mental Retardation Professional (MRCP) that she observed Client #2 in the bed with Client #2's finger inserted in Client #1's rectum. On October 19, 2009 at approximately 4:08 P.M., a phone interview was conducted with the direct care (Staff #1), who observed this incident. Staff #1 revealed that Client #1 and Client #2 shared a bedroom at the time of this incident. According to Staff #1, Client #2 no longer shares a bedroom with Client #1. Client #2 was given a bedroom alone. Further interview with Staff #1 revealed that the agency's incident policy was to report any unusual incident immediately to the management staff. Reportedly, Staff #1 waited to report her observation to management the following day when she arrived for duty at 3:30 P.M. The incident report was dated July 19, 2009 and was not reported until 5:00 P.M. on the proceeding day, which was approximately 17 hours later after she observed the incident. Staff #1 admitted that she failed to implement the agency incident reporting policy as she was trained to do. It should be noted that Staff #1 stated that she asked Client #2 to return to her bed. Client #2 responded by going to her bed and putting the top bed cover over her head. An interview with the Residential Manager (RM) as a part of the initial administrative review	W 149		

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W 149	Continued From page 3 process on August 25, 2009 revealed that Staff #1 informed her that she heard Client #1 yelling out loudly on the night of the incident. She was sitting in the office area on the same floor. She got up from the desk and went to her bedroom to check out what was happening and discovered Client #2 in Client #1 ' s bed. According to the RM, the staff did not immediately notify management staff and/or generate an incident report to document her observations. Reportedly, Staff #1 informed the RM that she had not encountered a situation of this nature before and was unclear on what she was to do. According to the RM, " Staff #1 had access to management around the clock, on a 24 hour basis by telephone".	W 149		
W 153	Note: It should be further noted that Client #1 was assigned a one on one counselor for her behavioral concerns. According to interview, Staff #1, whom was the assigned one on one staff person, was on break at the time of this incident. 483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that all allegations of neglect/abuse were reported timely as required by State Law as required by DC regulation (22	W 153	Cross reference W149	11/1/09

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W 153	Continued From page 4 DCMR Chapter 35 Section 3519.10), for one of the six clients residing in the facility. (Clients #1) The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of the facility's investigative reports on October 5 at 1:45 PM, revealed the facility failed to report an allegation of sexual advances to the administrator and other menagement timely as evidenced below: On August 20, 2009, the State Agency received written notification of an incident from this agency. According to the notification, the alleged incident occurred on August 18, 2009 at approximately 11:20 P.M. The incident report described that on August 19, 2009 at approximately 5:00 P.M. a direct care staff reported to the Qualified Mental Retardation Professional that she observed another client in the bed with Client #1. The other client had her finger in Client #1's rectum. Interview with the Residential Manager (RM) as a part of the initial administrative review process, on August 25, 2009, revealed that Staff #1 informed her that she heard Client #1 yelling out loudly on the night of the incident. She was sitting in the office area on the same floor. She got up from the desk and went to her bedroom to check out what was happening and discovered Client #2 in Client #1's bed. According to the RM, the staff did not immediately notify management staff and/or generate an incident report to document her observations. Reportedly, Staff #1 informed the RM that she had not encountered a situation of this nature before and was unclear on what she was to do. According to the RM, "Staff #1 had access to management around the clock, on a 24	W 153		

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W 153 W 154	Continued From page 5 hour basis by telephone. " 483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to ensure that abuse of a client residing in the facility was thoroughly investigated for one of the six clients residing in the facility. (Client #1) The finding includes: The facility failed to ensure that the reported allegation of abuse was investigated thoroughly as evidenced below: On August 20, 2009, the State Agency received written notification of an incident from this agency. According to the notification the alleged incident occurred on August 18, 2009 at approximately 11:20 P.M. The incident report described that on August 19, 2009 at approximately 5:00 P.M. a direct care staff reported to the Qualified Mental Retardation Professional that she observed another client in the bed with Client #1. The other client had her finger inserted in Client #1's rectum. An interview with the Residential Manager on August revealed that Staff #1 explained that she heard Client #1 yelling out loudly on the night of the incident and went to her bedroom. However, the investigative report did not specify how Staff #1 intervened to assist the Client #1 when she	W 153 W 154	1. Cross reference W104 2. Cross reference 1379 3. Cross reference W104 4. Cross reference W104	12/2/09 10/23/09 11/1/09 11/1/09

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W 154	Continued From page 6 discovered Client #2 in her bed. According to the RM, Staff #1 failed to immediately notify management staff. In addition, the staff failed to immediately generate an incident report to document her observation. The incident report dated July 19, 2009, which was the following day, indicated that an incident report was not generated until 5:00 P.M., which was approximately 17 hours after the incident occurred. The staff person explained that she had not encounter a situation of this nature before and was not clear on what she was to do. According to the RM the staff person had access to management around the clock or on a 24-hour basis. Review of the in-service training logbook on the same day confirmed that the agency trained all staff in January 2009 and July 2009 on the agency's incident management system. This training was not effective. Additionally staff was trained on the agency incident reporting system and procedures on September 25, 2009. On October 5, 2009 at approximately 2:34 P.M., a review of the agency's internal investigation failed to provide that the following details were included and documented in the internal investigation: 1. Client #1 was assigned as the one on one staff person. The investigation failed to explain where the one to one staff was at the time this incident occurred. 2. The rationale of the direct care staff that discovered this incident for not reporting this situation immediately to management staff on	W 154		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE 8, MEDICAID SERVICES

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COMMUNITY MULTI SERVICES, INC	4314 9TH STREET NW WASHINGTON, DC 20011

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W 154	Continued From page 7 call. 3. The investigation did not provide evidence of a clear explanation as to where the three staff on duty was in the group home at the time of the incident to help clarify who else may have witnessed the incident. 4. The internal investigation did not clearly describe how the staff intervened to assist the Client #1.	W 154		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observations, interviews with the Qualified Mental Retardation Professional (QMRP) and record review, the QMRP failed to ensure integration, coordination, and monitoring of client's active treatment regimen for one of the six clients residing in the facility. (Client #1) The findings include: 1. The QMRP failed to ensure that staff implemented the agency incident management policies consistently. (See W149) 2. The QMRP failed to ensure that each staff received effective training on the facility's incident management training in accordance with the agency's policies. (See W188)	W 159	Staff will continue to receive ongoing training on Incident Management Policies & Procedures. In the future, a comprehensive test will be given to ensure that the Incident Management training was effective. All incidents will be reported in a timely manner to be generated within twenty-four hours. Staff will receive additional training on the Incident Management Policy.	10/23/09
W 189	483.430(e)(1) STAFF TRAINING PROGRAM	W 189		

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	096031	A. BUILDING _____ B. WING _____	10/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MULTI SERVICES, INC	4314 9TH STREET NW WASHINGTON, DC 20011

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W 189	Continued From page 8 The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure that each employee had been provided with adequate training that enables the employee to perform his or her duties effectively, efficiently and competently for one of one staff in the facility. (Staff #1) The finding includes: [Cross refer to W149] The QMRP failed to ensure that all facility staff received effective training that included implementation of the incident management policy. On August 20, 2009, the State Agency received written notification of an incident from this agency. According to the notification the alleged incident occurred on August 18, 2009 at approximately 11:20 P.M. The incident report described that on August 19, 2009 at approximately 5:00 P.M. a direct care staff reported to the facility's Qualified Mental Retardation Professional (MRCP) that she observed another Client #2 in the bed. Client #2 had her finger inserted in Client #1's rectum. According to the RM, the Staff #1 failed to immediately notify management staff. In addition, the staff failed to immediately generate an incident report to document her observation. The incident report dated July 19, 2009, was not generated until 5:00 P.M. on the proceeding day,	W 189	Cross reference W159	10/23/09

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W 189	Continued From page 9 which was approximately 17 hours after the incident occurred. Reportedly, the staff explained that she had not encountered a situation of this nature before and was not clear on what she was to do. Further interview with the RM revealed that the staff person had access to management around the clock or on a 24-hour basis and had received training on incident management. Review of the in-service training logbook on the same day confirmed that the agency had trained all staff in January 2009 and July 2009 on the agency's incident management system. This training was not effective. Additional training was provided on September 25, 2009.	W 189		

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Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0052	A. BUILDING _____ B. WING _____	10/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MULTI SERVICES, INC	4314 9TH STREET NW WASHINGTON, DC 20011

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I 000	INITIAL COMMENTS On August 20, 2009, the State Agency received written notification of an incident from this agency. According to the notification, the alleged incident occurred on August 18, 2009 at approximately 11:20 P.M. The incident report described that on August 19, 2009 at approximately 5:00 P.M. a direct care staff reported to the Qualified Mental Retardation Professional (QMRP) that she observed another resident in the bed with Resident #1. The other client had inserted her finger in Client #1's rectum. Due to the nature of the incident and the information obtained from the administrative review, the Department of Health (DOH) Health Regulation and Licensing Administration (HRLA) initiated an investigation [#09-6465] was on October 5, 2009. The findings of the investigation were based on observations in the group home, interviews with the group home management, direct care staff, and the review of Administrative and Habilitation records to include the agency's incident management system. As a result of the findings, the State Agency could not substantiate that the sexual allegation was a pattern of Resident #2's behavior and continued as a violation of the rights of Resident #1 as reported in this incident. However, a determination was made that the facility failed to be incompliance with local state requirements as throughout this report.	I 000		
I 222	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel.	I 222		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MULTI SERVICES, INC	[redacted]

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I 222	Continued From page 1 This Statute is not met as evidenced by: Based on observations, interview and record verification, the GHMRP failed to ensure continuous, ongoing in-service training programs were conducted for one of the sixteen personnel. The finding includes: The GHMRP failed to ensure that incident management training was effective as evidenced below: Interview with the Residential Manager on August revealed that Staff #1 explained that she heard Client #1 yelling out loudly on the night of the incident and went to Client #1's bedroom. However, the investigative report did not specify how Staff #1 intervened to assist the Client #1 when she discovered Client #2 in her bed. According to the RM, Staff #1 failed to immediately notify the management staff. In addition, Staff #1 failed to immediately generate an incident report to document her observation. The incident report dated July 19, 2009, which was the following day, indicated that an incident report was not generated until 5:00 P.M., approximately 17 hours after the incident occurred. Reportedly, the staff explained that she had not encountered a situation of this nature before and was not clear on what she was to do. According to the RM the staff person had access to management around the clock on a 24-hour basis. Review of the in-service training logbook on the same day confirmed that the agency's trained all staff in January 2009 and July 2009 on the agency's incident management system. This training was not effective.	I 222	Staff will continue to receive ongoing training on Incident Management Policies & Procedures. In the future, a comprehensive test will be given to ensure that the Incident Management Training was effective.	10/23/09

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COMMUNITY MULTI SERVICES, INC	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 222	Continued From page 2 Additionally staff was trained on the agency incident reporting system and procedures on September 25, 2009.	I 222		
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that all incidents were reported immediately to the administrator or to other officials in accordance with State Law as required by DC regulation (22 DCMR Chapter 35 Section 3519.10), for one of the six clients residing in the facility. (Clients #1) The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of the facility's investigative reports on October 5 at 1:45 PM, revealed the facility failed to immediately report allegation of sexual advances to management and other officials as evidenced below: On August 20, 2009, the State Agency received written notification of an incident from this agency. According to the notification the alleged	I 379	In the future, all incidents will be reported in a timely manner, and an incident report will be generated within twenty-four hours or the next work day. Staff will receive additional training on the Incident Management Policy.	10/23/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0052	A. BUILDING _____ B. WING _____	10/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MULTI SERVICES, INC	4314 9TH STREET NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OEFICIENCY)	(X5) COMPLETE DATE
I 379	Continued From page 3 incident occurred on August 18, 2009 at approximately 11:20 P.M. The incident report described that on August 19, 2009 at approximately 5:00 P.M. a direct care staff reported to the Qualified Mental Retardation Professional (QMRP) that she observed another client in the bed with Client #1. The other client had her finger inserted in the Client #1's rectum. Interview with the Residential Manager (RM) as a part of the initial administrative review process on August 25, 2009 revealed that Staff #1 informed her that she heard Client #1 yelling out loudly on the night of the incident. She was sitting in the office area on the same floor. She got up from the desk and went to Client #1's bedroom to check out what was happening and discovered Client #2 in Client #1 bed. According to the RM, the staff did not immediately notify management staff and/or generate an incident report to document her observations. Reportedly Staff #1 informed the RM that she had not encounter a situation of this nature before and was unclear on what she was to do. According to the RM, " Staff #1 had access to management around the clock, on a 24 hour basis by telephone".	I 379		